FORMS TO BE RETURNED NO LATER THAN 6 WEEKS BEFORE TRAVEL.

Personal details

Name:	Date of birth:
Contact telephone number:	☐ Male ☐ Female
E-Mail:	GP:

Dates of trip

Date of departure:
Return date or overall length of trip:

Itinerary and purpose of visit

Countries to be visited	Length of stay	Away from medical help at destination? If so, how remote?
1.		
2.		
3.		
Any future travel plans?		

Please tick as appropriate below to best describe your trip

1. Type of trip	☐ Business	☐ Pleasure	☐ Other
2. Holiday type	☐ Package	☐ Self-organised	☐ Back-packing
	☐ Camping	☐ Cruise ship	☐ Trekking
3. Accommodation	☐ Hotel	☐ Relatives / family home	☐ Other
4. Travelling	☐ Alone	☐ With family/friend	☐ In a group
5. Staying in an area which is	☐ Urban	☐ Rural	☐ Altitude
6. Planned activities	☐ Safari	☐ Adventure	☐ Other

Personal medical history

Do you have any recent or past medical history of note? (including diabetes, heart or lung conditions)
List any current or repeat medications
Do you have any allergies; for example to eggs, antibiotics, nuts or latex?
Have you ever had a serious reaction to a vaccine given to you before?
Does having an injection make you feel faint?
Do you or any close family members have epilepsy?
Do you have any history of mental illness including depression or anxiety?
Have you recently undergone radiotherapy, chemotherapy or steroid treatment?
Women only: Are you pregnant or planning pregnancy or breastfeeding?
Have you taken out travel insurance and if you have a medical condition, informed the insurance company about this?
Please write below any further information which may be relevant

Vaccination history

Have you ever had any of the following vaccinations / malaria tablets and if so when?

☐ Tetanus	☐ Polio	☐ Diphtheria	☐ Typhoid
☐ Hepatitis A	☐ Hepatitis B	☐ Meningitis	☐ Yellow Fever
☐ Influenza	☐ Rabies	☐ Japanese B Encephalitis	☐ Tick Borne
☐ Other			
☐ Malaria Tablets			

For discussion when risk assessment is performed within your appointment:

I have no reason to think that I might be pregnant. I have received information on the risks and benefits of the vaccines recommended and have had the opportunity to ask questions. I consent to the vaccines being given.

Signed: ..... Date: .....

FOR OFFICIAL USE

Patient Name:

Travel risk assessment performed? ☐ Yes ☐ No

Travel vaccines recommended for this trip

Disease protection	Yes	No	Patient declined vaccine	Further information
Hepatitis A	☐	☐		
Hepatitis B	☐	☐		
Typhoid	☐	☐		
Cholera	☐	☐		
Tetanus	☐	☐		
Diphtheria	☐	☐		
Polio	☐	☐		
Meningitis ACWY	☐	☐		
Yellow Fever	☐	☐		
Rabies	☐	☐		
Japanese B Encephalitis	☐	☐		
Other	☐	☐		

Travel advice and leaflets given as per travel protocol

☐ Food, water and personal hygiene advice	☐ Traveller's diarrhoea	☐ Blood and bodily fluid infection risks e.g. Hepatitis B
☐ Insect bite prevention	☐ Animal bites	☐ Accidents
☐ Insurance	☐ Air travel	☐ Sun and heat protection
☐ Websites	☐ SMS vaccines reminder service set up	
☐ Travel record card supplied	☐ Other	

Malaria prevention advice and malaria chemoprophylaxis

☐ Chloroquine and proguanil	☐ Doxycycline	☐ Mefloquine
☐ Chloroquine	☐ Atovaquone and proguanil	☐ Malaria advice leaflet given

Further information

e.g. weight of child:

Authorisation for Patient Specific Direction (PSD) Use

Assessor's Name: ..... Signature: ..... Date: .....

Prescriber's Name: ..... Signature: ..... Date: .....